

Association Notes

TRAVELLING TO THE ANNUAL MEETING BY TRAIN?

Arrangements have been made with the Canadian Passenger Association to provide reduced convention rates for members and their families proceeding by rail to Toronto to attend the Annual Meeting. For adults the round trip fare is $1\frac{1}{2}$ times the normal one-way fare, plus twenty-five cents. Similar reductions are available for children.

The authorized dates for the start of the going journey have been established as follows:

(a) From all points west of Fort William and Armstrong, Ont. June 7 to 17 inclusive.

(b) From all points east of Fort William and Armstrong, Ont. (except Newfoundland). June 10 to 20 inclusive.

(c) From stations in Newfoundland. June 7 to 17 inclusive.

Identification certificates to permit members to purchase transportation under this plan may be obtained from the General Secretary, Canadian Medical Association, 244 St. George Street, Toronto 5, Ont.

C.M.A. REHABILITATION CONFERENCE

The Canadian Medical Association arranged a Conference on Rehabilitation which was held at the Royal York Hotel, Toronto, on February 18 and 19, 1955. In addition to a number of special speakers, conference participants included the C.M.A. Committee on Rehabilitation, the provincial co-ordinators of rehabilitation, the secretaries of C.M.A. divisions, and seven representatives of medical schools.

For geographical reasons, the majority of the papers given were by persons from Ontario, but participants from other provinces joined freely in discussion and gave the conference a distinctly national flavour.

The conference was opened on Friday morning, February 18, by the chairman, Dr. A. T. Jousse, who outlined the purpose of the meeting. He felt that the conference would reveal something of the nature and magnitude of the problem of rehabilitation in Canada, and that discussion would show the contribution to be expected from the three groups—organized medicine, the medical schools, and the government—represented. He stressed the need for team effort but pointed out that the best work would always be achieved if one medical man was at all times in charge of the patient's welfare. It was the duty of organized medicine to ensure respect of this principle. The medical school's responsibility for personnel training was clear; government had a primary responsibility to make rehabilitation available for all citizens requiring the service, while permitting freedom of action at the local level.

Dr. A. B. Stokes then outlined some aspects of the problem of rehabilitation of the mentally ill.

The second half of the morning session consisted of a panel discussion on the rehabilitation process at work,

with Dr. Jousse as moderator and Messrs. Bartlett, Mitchell and Price as discussants. Three patients were presented to the conference and their case histories were discussed to bring out such points as the value of the front-page story approach in job placement of the handicapped, the importance of community participation in rehabilitation, the need for joint effort in job finding, and the need for satisfying employers by careful placement of disabled trainees.

At the Friday afternoon session, Dr. K. C. Charron read a paper on "The economic and social consequences of ill health and disability on a national scale," in which he again stressed the need for medical leadership in a well-balanced rehabilitation programme.

Dr. D. J. Galbraith then discussed "The physician's responsibility for rehabilitation," beginning with the need for inculcating in the injured person the idea that he is going back to work, for informing the patient exactly of his prognosis, and for planning the whole course of treatment with the end result in view of restoration of working capacity. He described the role of the convalescent wing of the hospital and advocated the maintenance of control of the case throughout rehabilitation by the general practitioner, working with the necessary experts as a team.

At a dinner meeting, the President of the Canadian Medical Association, Dr. G. F. Strong, delivered an address entitled "Rehabilitation—a National Challenge," in which he said that rehabilitation is in somewhat the same position as public health and preventive medicine were 100 years ago, but that progress should be much more rapid than it had been in public health. He also stated that rehabilitation was essentially a medical programme under medical leadership. He discussed the problem under two heads—immediate needs and long-term requirements—and outlined the advantages and disadvantages of rehabilitation wings in hospitals and of community centres. The need for educating the public was stressed.

Saturday morning's session opened with a paper on industrial casualties by Dr. E. C. Steele, who stated that only 10% of such patients need specialized help, and only 2 to 3% need job placement. The troublesome nature of back injuries, and the difficulty of placing unskilled or older workmen, and sufferers with back pain or dermatitis, were emphasized. Successful rehabilitation, said Dr. Steele, must be economically rewarding and not merely on a humanitarian basis. It was a grassroots affair, carried out in and by the community.

Dr. W. Boothroyd then outlined the rehabilitation of psychiatric casualties, discussing not only those discharged from mental hospitals but also that 5% of the population which has a mental breakdown at some point in life. He particularly dwelt on the role of the local doctor who has to care for the discharged mental patient.

Dr. G. J. Wherrett described the rehabilitation of the tuberculous, mentioning that finances now permit rehabilitation as well as prevention and medical care in this field, and that sanatorium patients are now much less ill and therefore more amenable to re-education than they used to be.

Dr. J. S. Crawford described the arrangements in the general hospital in which he directs a rehabilitation programme. He discussed staffing difficulties and then gave details of treatment of various groups of patients. The hospital programme included: (1) treatment of in-patients, both public and private; (2) treatment of out-patients; (3) a teaching programme for physiotherapists, nurses, interns and the visiting medical staff.

At the Saturday afternoon session, Dr. J. A. MacFarlane read a paper on the education of doctors in rehabilitation. Doctors in general need education in the concept of rehabilitation. In addition, there is a need for training of rehabilitation medical officers. Facilities exist for such training but it is difficult to interest graduates in a long and financially insecure training period with few rewards at the end. Government support is

needed for a training programme, which should be centred on university teaching hospitals.

Dr. H. Hoyle Campbell then performed the very difficult task of summarizing the thinking of the meeting. It is expected that the Committee on Rehabilitation of the Canadian Medical Association, guided by the expressions of opinion at the conference, will draw up a statement of the policy of organized medicine in Canada, as represented by the Canadian Medical Association, on rehabilitation. This statement will be presented to the Executive Committee of the C.M.A. for its consideration.

THANK YOU, FELLOW-TRAVELLERS!

THE ANNOUNCEMENT in the January 15 issue of the Journal to the effect that the B.M.A.-C.M.A. currency exchange plan was open for the current year has brought such a flood of offers from Canadian doctors that the quota is filled. The arrangement authorized by the Bank of England permits only three British Medical Association members per year to deposit £200 and to receive \$560 on arrival in Canada, and the prompt and generous response of travelling Canadian doctors has over-subscribed the fund.

We are grateful for the interest of Canadian Medical Association members in all parts of the country but the rules will not permit us to accept further deposits of Canadian funds. If you require sterling for travel in Britain, please obtain it through normal banking channels as the B.M.A.-C.M.A. currency exchange plan is closed until early 1956. A.D.K.

CORRESPONDENCE

TRICHINOSIS

To the Editor:

The treatment of most helminth infestations is notoriously difficult and we should welcome any attempt to improve this unsatisfactory state of affairs.

In the assessment of any therapeutic measure the first requirement would appear to be an unequivocal diagnosis. Dr. J. J. Fortier (*Canad. M. A. J.*, 72: 298, 1955) has described the treatment of three cases of trichinosis with ACTH and cortisone. There is fairly strong circumstantial evidence in the three case histories to suggest *Trichinella spiralis* infestation but in none of them was the larva clearly demonstrated in voluntary muscle. The three patients were exhaustively investigated but the significant findings were limited to: (1) a history of eating raw pork; (2) eosinophilia; and (3) positive *Trichinella* skin tests.

Raw or poorly cooked pig meat is frequently ingested by humans, particularly those with the Central European and Italian habit of using spiced sausages. Eosinophilia is, as yet, a largely unexplained phenomenon; however, it is known to occur in certain conditions of which Wintrobe (*"Clinical Hematology,"* 3rd ed.) lists more than twenty. Thus its presence is merely an indication for further investigation and a limiting factor in the

differential diagnosis. The *Trichinella* skin test is not specific, as group reactions have been described in patients harbouring helminths other than *Trichinella spiralis* and false positive and non-specific reactions occur (described by Stitt in "Practical Bacteriology, Haematology and Parasitology" and by Strong in "Stitt's Tropical Diseases").

There is no doubt that, as a physician, Dr. Fortier relieved the patients of their symptoms but I suggest that, in the absence of a clear demonstration of the parasite, he has failed to prove the value of ACTH and cortisone in trichinosis. D. SHUTE, M.D., D.T.M.

Provincial Laboratory
of Public Health,
Calgary, Alta., March 1, 1955

WATER SOFTENING AND LOW-SODIUM DIETS

To the Editor:

The increasing use of water-softening equipment should not be overlooked by physicians in the care of patients who require a low-sodium diet.

It was brought forcibly to my attention recently by a patient who had been digitalized and on a low-sodium diet for congestive failure, with satisfactory results, for an extended period of time. When she began to get oedematous again, she herself surmised that the water-softening equipment, installed some weeks before, was to blame.

Upon having the softened water and the ordinary water tested for sodium, there was found to be a ten-fold increase in the former. Simply discontinuing use of the water-softener was sufficient to return the patient to cardiac compensation.

Inquiry among my colleagues revealed that they too had either not known or had forgotten this possible source of difficulty in enforcing a low-sodium diet. If this is generally the case, I thought it might be desirable to focus attention on it through these columns.

It is true that some of the low-sodium diet sheets mention the avoidance of softened water. However, it may be overlooked or forgotten in the mass of detail such a diet entails. In addition, patients living in rented quarters may not think about the possibility of the water supply's having been treated by a softening process.

St. Thomas, Ont.
Feb. 16, 1955.

E. L. BROWN, M.D.

SPECIAL CORRESPONDENCE

The London Letter

(From our own correspondent)

PARLIAMENT AND PROPRIETARIES

Matters of medical interest have been very much to the fore in the House of Commons recently. One reason for this is that the Minister of Health had to ask for a supplementary estimate of £5 million, the sum by which his department had underestimated the cost of the National Health Service during the current fiscal year. As practically half of this sum was attributable to the increased cost of the pharmaceutical services, there was the usual attempt by the opposition to lay the blame on the pharmaceutical companies. The Minister of Health had to admit that a "major factor in the increased cost"